A GUIDE TO MEDICARE

HEALTH CARE FINANCING ADMINISTRATION SEPTEMBER 1977

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WHAT IT IS

WHO CAN QUALIFY

WHAT IS COVERED

WHAT IT COSTS

HOW PAYMENT IS MADE

HOW A CLAIM IS APPEALED

THE ROLE OF THE SOCIAL SECURITY OFFICE

GLOSSARY OF TERMS

This booklet is designed to highlight the Medicare program, primarily for use by employees of the Health Care Financing Administration, the Social Security Administration, and by others involved in the administration of Medicare.

The information presented is not all inclusive and does not take the place of regulations, operating procedures, or manual instructions.

HEALTH CARE FINANCING ADMINISTRATION
Medicare Training Staff

Two programs of health insurance protection

- Hospital insurance—Part A

  Covers hospitalization and related care

- Medical insurance—Part B

  Covers physicians' care and other health services

Words **CAPITALIZED** in **BOLD PRINT** are defined in the **GLOSSARY**

WHAT IT IS

Part A—Hospital Insurance

People age 65 and older
and
Entitled to monthly
Social security (SS) benefits
or
Railroad retirement (RR)
annuity

or

People age 65 and older
and
Ineligible for SS or RR benefits
and
DEEMED INSURED
and
A U.S. resident
and
A U.S. citizen (or alien lawfully admitted for permanent residence with 5 years continuous residence)
and

(see next page)

Part B —Medical Insurance

People entitled to Part A

or

People age 65 and older
and
A U.S. resident
and
A U.S. citizen (or alien lawfully admitted for permanent residence with 5 years continuous residence)

- Eligible people have **AUTOMATIC ENROLLMENT** in Part B unless they specifically decline

- Enrollment request necessary by person who:
  —is not already an SS or RR beneficiary
  or
  —has previously declined Part B Medical Insurance
  or

(see next page)

WHO CAN QUALIFY

WHO CAN QUALIFY

Part A—Hospital Insurance

Not covered and (with some exceptions) could not have been covered under Federal Employees' Health Benefits Act of 1959
Note: **DEEMED INSURED** provision applies only to women who attained age 65 before 1974, and to men who attained age 65 before 1975

or

People age 65 and older
and
Enrolled in Part B
and
Meeting citizenship and residency requirements
and
Not otherwise eligible
May voluntarily enroll in Part A
(must pay a monthly premium—
PREMIUM HI)

or

People any age
Entitled (or deemed entitled) to disability-based benefits for the 24 preceding months

or

(see next page)

Part B —Medical Insurance

—has terminated Part B Medical Insurance (voluntarily or involuntarily)

■ Entitlement not retroactive

Part A—Hospital Insurance

People under age 65
With chronic renal disease (CRD) requiring transplant or dialysis and either:
(a) SS beneficiary or RR annuitant, or
(b) Fully or currently insured (railroad work may count), or
(c) Spouse or dependent child of (a) or (b)

- Application must be filed
- Retroactive for up to 12 months (except **PREMIUM HI**—no retroactivity)

Note: No formal application required under CRD provision and retroactivity not limited to 12 months

WHO CAN QUALIFY

Part A—Hospital Insurance

3 major services:

1. **Inpatient hospital care**
   Includes:

   - Up to 90 days per **BENEFIT PERIOD** (renewable in subsequent benefit periods) plus 60 days **LIFETIME RESERVE** (nonrenewable) in a **PARTICIPATING** hospital
   - Psychiatric hospital care (190 days lifetime limit)
   - Semiprivate room and board
   - Operating room
   - Special care units
   - Recovery room
   - Drugs, medical supplies and appliances furnished by the hospital
   - Laboratory tests, x-ray, and radiological services
   - Rehabilitation services
   - Medical social services

(see next page)

Part B —Medical Insurance

Includes:

- Physicians' services (and services and supplies furnished incident to a physician's professional service)
- Outpatient hospital services:
  —incident to physicians' services
  —diagnostic and therapeutic services provided by a **PARTICIPATING** hospital (for **EMERGENCY SERVICES** may sometimes be by a nonparticipating hospital)
- Diagnostic tests:
  —x-ray
  —lab tests
- Therapy
  —x-ray
  —radium
  —radioactive isotope
- Limited chiropractic services

(see next page)

WHAT IS COVERED

WHAT IS COVERED

Part A—Hospital Insurance

- **EMERGENCY SERVICES** (can also be covered in nonparticipating hospitals under certain conditions)

Excludes:

- ○ Services not reasonable and necessary for diagnosis or treatment of illness or injury
- ○ Personal comfort items
- ○ Private duty nurses
- ○ Physicians' services (may be covered under Part B)
- ○ Private room (unless medically necessary)
- ○ Noncovered **LEVEL OF CARE**

2. Extended care
Includes:

- Up to 100 inpatient days in a **PARTICIPATING** skilled nursing facility (**SNF**) per **BENEFIT PERIOD**
- Semiprivate room and board
- Regular nursing services

(see next page)

Part B —Medical Insurance

- ■ Other medical supplies such as:
  —splints
  —casts
  —devices used for reduction of fractures and dislocations
- ■ Durable medical equipment for use in patient's home (rental or purchase) including home dialysis equipment and supplies
- ■ Chronic renal disease facility care by approved suppliers of maintenance dialysis services
- ■ Certain ambulance services
- ■ Prosthetic devices replacing all or part of an internal body organ (including prosthetic eyeglasses and contact lenses which replace the lens of the eye removed during cataract surgery)
- ■ Braces for arm, leg, back, neck
- ■ Artificial arms, legs, eyes
- ■ Home health services—up to 100 visits in a calendar year, in addition to Part A visits (same requirements as Part A except prior hospitalization not required)

(see next page)

Part A—Hospital Insurance

- Drugs, medical supplies and appliances furnished by the **SNF**
- Therapy (physical, occupational, speech)
- Medical social services

Note: Admission to the SNF must follow, within 14 days, a qualifying hospital stay of at least 3 consecutive days (the 14-day requirement may be extended under certain conditions)

Beneficiary must:

–Be admitted for further treatment of a condition treated in the hospital
–Require skilled nursing care or other skilled rehabilitation services on a daily basis

—which—

as a practical matter can only be provided in the SNF on an inpatient basis

Excludes:

- ○ Services not reasonable and necessary for diagnosis or treatment of illness or injury
- ○ Personal comfort items

(see next page)

Part B —Medical Insurance

- ■ Outpatient physical therapy and speech pathology by a **PARTICIPATING** hospital, **SNF, HHA,** or approved clinic, rehabilitation agency or public health agency
- ■ Coverage of services of independently practicing physical therapists (up to $100 of **REASONABLE CHARGES** per calendar year)

Excludes:

- □ Items and services not reasonable and necessary for diagnosis or treatment of illness or injury
- □ Routine physical check-ups
- □ Hearing aids, eyeglasses and examinations for fitting them (exception: see prosthetic devices above)
- □ Immunizations (except where immediate risk of infection)
- □ Cosmetic surgery
- □ Dental services (for example, treatment, filling, removal or replacement of teeth)
- □ Routine and certain other foot care

(see next page)

WHAT IS COVERED

WHAT IS COVERED

Part A—Hospital Insurance

- ○ Private duty nurses
- ○ Physicians' services (may be covered under Part B)
- ○ Private room (unless medically necessary)
- ○ Noncovered **LEVEL OF CARE**

3. Home health services

Covered only if beneficiary:

- confined to home
- under care of physician
- under home health plan established by physician within 14 days after discharge from hospital or **SNF**
- needs intermittent or part-time skilled nursing care or physical or speech therapy for condition for which he received inpatient hospital or extended care services
- is provided services within year following most recent discharge from 3-day hospital or covered SNF stay, whichever is later

Include:

- Up to 100 visits from a **PARTICIPATING** home health agency (**HHA**) after start

(see next page)

Part B —Medical Insurance

- ☐ Orthopedic shoes (unless part of a leg brace) and other supportive devices for the feet
- ☐ Prescription drugs

Part A—Hospital Insurance

of one **BENEFIT PERIOD** and before start of next

- Part-time nursing care
- Therapy (physical, occupational, speech)
- Part-time services of home health aides
- Medical supplies and appliances furnished by the **HHA**
- Medical social services

Exclude:

- ○ Services not reasonable and necessary for diagnosis or treatment of illness or injury
- ○ Full-time nursing care
- ○ Drugs and biologicals
- ○ Personal comfort items
- ○ Meals delivered to the home
- ○ Homemaker services
- ○ Physicians' services (may be covered under Part B)
- ○ Noncovered **LEVEL OF CARE**

WHAT IS COVERED

Part A—Hospital Insurance

• No monthly premium
(Except for **PREMIUM HI**)

Inpatient hospital care

Program pays **REASONABLE COSTS** *after:*

- Inpatient hospital **DEDUCTIBLE** per **BENEFIT PERIOD**
  - –Amount determined each year by the Secretary of DHEW
  - –Approximates the national average cost of a 1-day hospital stay
  - –Changes effective for benefit periods beginning on or after January 1
- **COINSURANCE** from 61st through 90th day
  - –Equals ¼ of inpatient hospital deductible
- Coinsurance during **LIFETIME RESERVE**
  - –Equals ½ of inpatient hospital deductible
- Blood deductible—first 3 pints (or equivalent units of packed red blood cells) per benefit period

(see next page)

Part B —Medical Insurance

- Monthly premium
  (may be increased for late enrollment)

Program pays 80% of **REASONABLE CHARGES** *after:*

- Annual **DEDUCTIBLE**
  (amounts applied to the deductible must be the reasonable charges)
- **COINSURANCE**—20%
- Blood deductible—first 3 pints (or equivalent units of packed red blood cells) in a calendar year

Exceptions:

—For inpatient services of pathologists and radiologists—no deductible nor coinsurance
—For Part B home health services—deductible applies but not coinsurance
—For outpatient physician treatment of mental illness—only 62½% of reasonable charges (maximum of $312.50 per calendar year) may be allowed for benefit computation; after subtraction of any unmet deductible, the benefit is 80% of this adjusted amount
(In effect, this limits the amount that Medicare can pay for these services to $250 in any one year)

WHAT IT COSTS

WHAT IT COSTS

Part A—Hospital Insurance

Extended care

- **COINSURANCE** from 21st through 100th day
  –Equals ⅛ of inpatient hospital deductible

Home health services

- No **DEDUCTIBLE** or coinsurance for home health services

Note: Premiums, like deductible and coinsurance amounts, are subject to change. Premiums may change effective with July 1 of any year.

Part A—Hospital Insurance

PROVIDER performs a service for a Medicare beneficiary

▼

Provider files claim

▼

Claim is processed and paid by the **INTERMEDIARY** (or **DDR**)

▼

Provider receives payment

▼

Beneficiary receives "Medicare Hospital, Extended Care, and Home Health Benefits Record," an explanation of payments made on his behalf

▼

Provider has agreed not to charge Medicare beneficiary for covered items and services, but can bill for **DEDUCTIBLE, COINSURANCE,** and noncovered items and services

(For certain noncovered items and services, **WAIVER OF LIABILITY** provision may apply)

Part B —Medical Insurance

Two Methods of Filing

- Assignment Method
  - —Must be agreed to by both the beneficiary and the physician or supplier
  - —Physician or supplier files claim
  - —Payment is made by the **CARRIER** directly to the physician or supplier
  - —Beneficiary receives "Explanation of Medicare Benefits" (EOMB)
  - —Physician or supplier agrees to accept **REASONABLE CHARGE** as full charge
  - —Physician or supplier can bill the patient for no more than the unmet **DEDUCTIBLE, COINSURANCE,** and for noncovered items and services
  - —For certain noncovered items and services **WAIVER OF LIABILITY** provision may apply
- Nonassignment Method
  - —Beneficiary sends SSA–1490 directly to the carrier with itemized bill (or with Part II of SSA–1490 completed by physician)
  - —Beneficiary receives EOMB and payment directly
  - —Medicare payment to beneficiary is based on reasonable charge but physician or supplier is not restricted to reasonable charge
  - —Waiver of liability provision does not apply to nonassignment method
- Payment is made by carrier except when a **PROVIDER** (hospital, **SNF,** or **HHA**) furnishes Part B services; payment is then made by the **INTERMEDIARY** in the same manner as outlined under Part A (see left side of this page)

HOW PAYMENT IS MADE

Part A—Hospital Insurance **Part B —Medical Insurance**

A person denied Medicare benefits or in disagreement with the amount of benefits payable may appeal the decision on his claim as follows:

Issues involving benefits payable under Part A

Reconsideration
Use SSA–2649
60 days for filing

Hearing
Use HA–501.1
60 days for filing
Disputed amount must be $100 or more

Appeals Council Review
Use HA–520
60 days for filing

Judicial Review
60 days for filing
Disputed amount must be $1,000 or more

Issues involving benefits payable under Part B

Review
Use SSA–1964
6 months for filing

Hearing
Use SSA–1965
6 months for filing
Disputed amount must be $100 or more

———

No Judicial Review provided

Issues involving Medicare entitlement or enrollment

Reconsideration
Use SSA–561
60 days for filing

Hearing
Use HA–501
60 days for filing

Appeals Council Review
Use HA–520
60 days for filing

Judicial Review
60 days for filing

All time limits subject to extension for "good cause"

HOW A CLAIM IS APPEALED

The Social Security Office

serves as focal point for interrelationships between the beneficiary and the organizations which administer and operate the Medicare program

The social security office may assist in any of the following ways:

- Establish entitlement to Hospital Insurance—Part A
- Enrollment for Medical Insurance—Part B
- Explain benefits available under Part A and Part B
- Assist beneficiaries in claiming Part A and Part B benefits
- Assist in filing claims for hospital **EMERGENCY SERVICES**
- Assist direct-dealing **PROVIDERS** in filing for Part A and Part B benefits (See **DDR**)
- Obtain correct HI claim numbers for providers, **INTERMEDIARIES, CARRIERS,** and others
- Assist other components in resolving problems related to Part A and Part B claims
- Explain benefits paid to or on behalf of beneficiaries
- Explain appeal rights and assist claimants in filing appeals
- Assist beneficiaries in obtaining correct Medicare cards
- Assist beneficiaries in forwarding premiums
- Receive and refer complaints of violations of title VI of the Civil Rights Act
- Assist in maintaining the integrity of the Medicare program by identifying potential fraud and program abuse
- Promote public awareness of Medicare protection through public information programs

THE ROLE OF THE SOCIAL SECURITY OFFICE

► AUTOMATIC ENROLLMENT

The procedure whereby:

–Retirement and survivors' insurance (RSI) beneficiaries, and those entitled to disability-based benefits, are sent Medicare cards 3 months before the attainment of age 65, or (in disability cases) 3 months before the completion of 24 consecutive months of entitlement. These Medicare cards show entitlement to both hospital insurance (HI) and supplementary medical insurance (SMI). The SMI enrollment is automatic unless declined by the beneficiary, in writing, no later than the month prior to the effective date of coverage.

—also—

–People filing initial RSI claims outside their initial enrollment period (IEP) or a general enrollment period (GEP) to establish entitlement to hospital insurance (often retroactive) are deemed automatically enrolled in SMI in the next GEP unless they specifically decline.

► BENEFIT PERIOD

The time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. It ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary can have.

► CARRIER

An organization which has entered into an agreement with DHEW to process claims under the Medical Insurance program (Part B).

► COINSURANCE—GENERAL

The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per-day dollar amount, and under Part B it is a percentage of reasonable charges.

► COINSURANCE—PART A

–Hospital—From the 61st through the 90th day, the daily coinsurance amount is equal to ¼ of the inpatient hospital deductible.

–Lifetime reserve—For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to ½ of the inpatient hospital deductible.

–SNF—From the 21st through the 100th day, the daily coinsurance amount is equal to ⅛ of the inpatient hospital deductible.

► COINSURANCE—PART B

After the annual deductible has been met, Medicare pays 80% of reasonable charges for covered services and supplies (see exceptions under What It Costs). The remaining 20% of reasonable charges is the coinsurance.

► DEDUCTIBLES—PART A

–Inpatient hospital deductible—An initial amount in each benefit period (reflecting the national average charge per day in a hospital) which Medicare does not pay.

–Blood deductible—The first 3 pints of blood (or equivalent units of packed red blood cells) administered in each benefit period for which Medicare does not pay.

► DEDUCTIBLES—PART B

A dollar amount per calendar year which must be incurred for Part B expenses before Medicare starts to pay. Expenses incurred in the last 3 months of a year which are applied toward the deductible for that year may also be used toward the deductible for the following year.

There is a separate 3-pint blood deductible per calendar year under Part B which applies in the same way as the Part A blood deductible.

► DEEMED INSURED

This provision requires 3 quarters of coverage (QC's), whenever acquired, for each year after 1966 and before the year of attainment of age 65. No QC's are needed for persons age 65 before 1968 or for Premium HI enrollees. *Note:* No QC's are needed to enroll in Part B.

GLOSSARY OF TERMS

► **DDR**
Division of Direct Reimbursement, Bureau of Health Insurance, Health Care Financing Administration. Acts as an intermediary for providers who elect to deal directly with the Federal Government.

► **EMERGENCY SERVICES**
Hospital services which are necessary to prevent the death or serious impairment to the health of the individual, necessitating the use of the most accessible hospital equipped to furnish the services. If certain conditions are met, partial payment may be made for such services furnished by nonparticipating hospitals.

► **ENROLLMENT PERIOD**
There are two kinds of enrollment periods during which a person can voluntarily enroll for Part B:

–Initial Enrollment Period (IEP)—The 7-month period beginning 3 months before and ending 3 months after the month a person first meets all eligibility requirements. Effective date of coverage depends upon the month of enrollment.
–General Enrollment Period (GEP)—January 1 through March 31 of each year. Coverage effective July 1 of that year.

► **HHA**
Home Health Agency. An agency meeting certain requirements which provides health care in the home (see PARTICIPATING). Among services provided are part-time skilled nursing care, and physical, occupational or speech therapy. Coverage is available under both Part A and Part B.

► **INTERMEDIARY**
An organization which has entered into an agreement with DHEW to process Medicare claims (usually Part A) from providers of services.

► **LEVEL OF CARE**
To qualify for Medicare benefits for inpatient hospital, skilled nursing facility, or home health services, a beneficiary must both *need* and *receive* a certain type and degree of health care (i.e., a certain "level of care"). This "level of care" will vary among the 3 types of providers (hospitals, SNF's and HHA's). For Medicare reimbursement to be made, both the type of provider and the care provided to the beneficiary must be appropriate to the beneficiary's medical needs.

► **LIFETIME RESERVE**
Additional days of inpatient hospital care the beneficiary may draw upon after he has used 90 days in a benefit period. Reserve days used cannot exceed 60 during his lifetime.

► **PARTICIPATING**
To participate in the Medicare program, providers must meet certain standards which help assure that they will be able to provide acceptable health care, and they must enter into a formal agreement with the Federal Government. In general, payments are made only to providers who are participating in the Medicare program.

► **PREMIUM HI**
The term used to describe hospital insurance obtainable by timely application and payment of a monthly premium by individuals age 65 and older not otherwise eligible for HI (effective 7/1/73).

► **PROVIDER**
An institution or agency which provides health care services. Hospitals, skilled nursing facilities (SNF's), and home health agencies (HHA's) are the major providers.

► **REASONABLE CHARGE**
An individual charge determination made by a carrier for a covered Part B medical service or supply. In the absence of unusual medical circumstances it is the lowest of (1) the physician's or supplier's customary charge for that service; (2) the prevailing charge for similar services in the locality; and (3) the actual charge made by the physician or supplier.

► **REASONABLE COST**
The basis for payments (usually Part A) to participating providers. Reimbursement is based on the reasonable cost of providing services or the customary charges for such services, whichever is less.

► **SNF**
Skilled Nursing Facility. An institution such as a skilled nursing home or rehabilitation center. It is designed for the patient who no longer needs the intensive care of a hospital but who still needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which he received inpatient hospital services and which—as a practical matter—can only be provided in a SNF on an inpatient basis. To be certified as an SNF, the institution must meet certain conditions (see PARTICIPATING).

► **STATE BUY-IN**
A State may provide Part B coverage for its needy eligible persons through an agreement with the Federal Government under which the State enrolls the individuals and pays the premiums for them.

► **WAIVER OF LIABILITY**
A provision of Medicare which grants relief to a beneficiary who acted in good faith in accepting services, believing them to be covered by Medicare and finding later that they are not—for one of two reasons: either the services are determined not to be "reasonable and necessary" or they are determined to constitute "custodial care." The beneficiary may not be held liable for payment of these services if he did not know (and could not reasonably be expected to have known) that the services provided were not covered. The Medicare program itself will assume liability if *neither* the beneficiary nor the provider knew (or could reasonably be expected to have known) that the services were not covered.

Comments on
A Guide to Medicare

As a user of this booklet, your opinion on the following is solicited:

1. In what way did you find the booklet useful?

2. How would you improve the booklet?

3. What Medicare topics would you suggest for similar publications?

4. What is your organization and position?

Address comments to:

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Additional copies of this booklet can be obtained by contacting your servicing Health Insurance Regional Office or by writing to Health Care Financing Administration, Bureau of Health Insurance, Division of Management, Administrative Services Section, Baltimore, Maryland 21235.